Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

Rare Diseases of Public Health Significance

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

Disease:

County:

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	Fever Highest measured temp: _____ °F
				Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	Headache
☐	☐	☐	☐	Difficulty breathing
☐	☐	☐	☐	Confusion
☐	☐	☐	☐	Tremors or hand shakes
☐	☐	☐	☐	Seizures new with disease
☐	☐	☐	☐	Muscle aches or pain (myalgia)
☐	☐	☐	☐	Diarrhea
☐	☐	☐	☐	Vomiting
☐	☐	☐	☐	Rash

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Abnormal neurologic findings
☐	☐	☐	☐	Altered mental status
☐	☐	☐	☐	Paralysis or weakness
				☐ Acute flaccid paralysis ☐ Asymmetric
				☐ Symmetric ☐ Ascending ☐ Descending
☐	☐	☐	☐	Pneumonitis
☐	☐	☐	☐	Pneumonia
☐	☐	☐	☐	Rash observed by health care provider
☐	☐	☐	☐	Complications, specify: _____
☐	☐	☐	☐	Leukocytosis
☐	☐	☐	☐	Admitted to intensive care unit
☐	☐	☐	☐	Preliminary diagnosis established
				Diagnosis: _____
☐	☐	☐	☐	Final diagnosis established
				Diagnosis: _____

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

P	N	I	O	NT	
☐	☐	☐	☐	☐	Specimens collected for lab testing

Date: ___/___/___
Specimen type: _____
Results: _____
_____
_____

Date: ___/___/___
Specimen type: _____
Results: _____
_____
_____

Date: ___/___/___
Specimen type: _____
Results: _____
_____
_____

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

EXPOSURES

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____
_____
_____

☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

☐ ☐ ☐ ☐ Contact with recent foreign arrival
Specify country: _____

☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed human case**

☐ ☐ ☐ ☐ Case knows anyone with similar symptoms

☐ ☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care
☐ Dormitory ☐ Boarding school ☐ Camp
☐ Shelter ☐ Other: _____

Y N DK NA

☐ ☐ ☐ ☐ Outdoor or recreational activities (e.g. lawn mowing, gardening, hunting, hiking, camping, sports, yard work)

☐ ☐ ☐ ☐ Insect or tick bite
☐ Deer fly ☐ Flea ☐ Mosquito ☐ Tick
☐ Louse ☐ Other: _____ ☐ Unk
Location of insect or tick exposure
☐ WA county ☐ Other state ☐ Other country
☐ Multiple exposures ☐ Unk
Date of exposure: ___/___/___

☐ ☐ ☐ ☐ Employed in laboratory

☐ ☐ ☐ ☐ Occupational exposure
Occupation: _____
Date of exposure: __/__/__

☐ ☐ ☐ ☐ Blood, organ or tissue transplant recipient
Date of receipt:__/__/__

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___
Agency and location: _____
Specify type of donation: _____

☐ ☐ ☐ ☐ Suspected person to person transmission

☐ ☐ ☐ ☐ Outbreak related

☐ ☐ ☐ ☐ Bioterrorism related

PUBLIC HEALTH ACTIONS

☐ Isolation precautions

☐ Prophylaxis of appropriate contacts recommended:
☐ Household members ☐ Roommates
☐ Child care contacts ☐ Playmates ☐ Other children
☐ Other patients ☐ Medical personnel ☐ EMTs
☐ Co-workers ☐ Teammates ☐ Carpools
☐ Other close contacts: _____

☐ Notify blood or tissue bank

☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___